OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_401_33F
Offer Name: Iowa Medicaid – Maintaining Access – Medically Necessary Services
This offer is for improving an existing activity (describe the improvements in your narratives below)
Result(s) Addressed: Improve Iowan's Health, Building the New Economy
Participants in the Offer: Iowa Department of Human Services
Person Submitting Offer: Kevin Concannon
Contact Information: Eugene I. Gessow, 281-6249, egessow@dhs.state.ia.us

OFFER DESCRIPTION

This is an offer to provide all State Plan services which are not "mandatory" under Title XIX, ***but which are medically necessary and currently covered by Iowa Medicaid****, to make those rate adjustments currently contemplated by Iowa statute or regulation, and to eliminate all waiting lists for home and community based care services to promote the further rebalancing for long term care, and to distribute 100% of the State's increase in Disproportionate Share Dollar since 2004 to Iowa hospitals.*

DHS offers to provide the following **medically necessary "optional" services** to all adults eligible under Medicaid (these same services are mandatory for children and, therefore, included in DHS Offer No:H_401_07

Prescription Drugs ($78,761,978) – This offer contemplates the shift of all dual eligibles to the Medicare Part D pharmacy benefit beginning January 1, 2006.

Note: This offer does not anticipate any savings to the State as a result of the shift of duals to Medicare Part D because of the way the "claw-back" payment is to be calculated. The claw-back payment amount will not take into account any of the pharmacy cost reduction strategies implemented by the State subsequent to 2003

Note: This offer does not include any funds for a State Pharmacy Assistance Program to "wrap around" the new Medicare Part D pharmacy benefit.

Note: In the past two years the State has taken a number of steps to control the costs of prescription drugs. These include: reducing dispensing fees paid to pharmacies, expanding the SMAC, reducing payments to pharmacies for brand name drugs, substituting generic drugs for brand drugs, except when on post rebate basis generics are less expensive, increasing co-payments, and improving pharmaceutical rebate collections. Modest steps were taken in the area of pharmaceutical case management.

Home and Community Based Services (HCBS) Waivers ($26,940,072) – Waiver programs maintain persons in their own homes or communities who would otherwise qualify for more expensive care in a medical institution. This offer includes $7,687,570 to eliminate waiting lists for all home and community based waiver services in SFY 2006.

Note: A significant amount of the non-State dollars for waiver services for adults is paid by counties.. Those county dollars are, therefore, not included in this Offer or anywhere else in the State's budget. However, eliminating this "optional" service, would require eliminating the county funded and state funded service. As a practical matter this would mean a dramatic cost shift to counties.

Note: DHS, together with other partners in State government, are exploring several strategies for expanding the use of waiver services with concomitant reductions in hospital and other institutional services. These include: development of a universal assessment tool to help individuals identify alternatives to nursing home care before they leave the hospital, requesting federal authority to raise the level of care required to qualify for nursing home services without raising the level of care required for waiver services; providing all individuals who qualify for any waiver (the State has six today) access to the same waiver services; reducing the time it takes to process a waiver application where that would produce earlier access to home and community based services; the utility of a case-mix adjusted evaluation of eligibility for waiver services where waiting lists do exist. No funds have been included in this offer for implementing any of these changes.

ICF/MR State Cases ($3,871,798) – ICFs/MR provide 24-hour care with continuous active treatment for individuals with mental retardation.

Note: counties pay Most of the non-State dollars for ICF/MR services for adults. Those county dollars are, therefore, not included in this Offer or anywhere else in the State's budget. However, eliminating this "optional" service would require eliminating the county funded and state funded service. As a practical matter this would mean a dramatic cost shift to counties.

Note: DHS believes that Iowa properly can and should reduce the State's reliance on ICF/MR services in favor of community-based care alternatives. Implementing such a change is a complex undertaking which must take into account the needs of patients and their families, required "infrastructure", including but not limited to providers and systems for tracking the implementation of care plans in non-institutional settings, the role of counties in service delivery to this population, and changes in federal Medicaid policy.

Ambulance Services ($668,612) – This includes a very limited amount for non-emergency ambulance transportation, where appropriate alternatives are not available.

Clinic Services, primarily Kidney Dialysis ($714,099) – Patients in need of this service are at risk for severe bodily dysfunction and death.

Hospice Services ($4,552,231) – Hospice services, while justified solely from a care quality perspective, may also produce savings in such areas as hospital and physician services.

Dental ($7,371,738) – Absent general and preventive care, emergency situations could develop where patients would seek care in emergency rooms where the cost of treatment would far outweigh the cost of prevention.

Medical Supplies & Durable Medical Equipment ($9,260,050) – Basic activities of daily living are supported by this service.

Adult Rehab Option (ARO) State Cases ($2,373,746) – Chronically mentally ill individuals are provided rehabilitative skills training and supports to promote their ability to be integrated in the community and avoid intensive and expensive levels of service such as inpatient psychiatric hospitalization.

Note: counties pay Most of the non-Federal dollars for ARO services for adults. Those county dollars are, therefore, not included in this Offer or anywhere else in the State's budget. However, eliminating this "optional" service, would require eliminating the county funded and state funded service. As a practical matter this would mean a dramatic cost shift to counties.

Targeted Case Management ($4,279,611) – Absent coordination of services for chronically mentally ill, mentally retarded, or developmentally disabled individuals, other more costly services including hospitalization and emergency hospital visits, and increased medication usage, physician visits, and counseling services would occur.

Note: counties pay half of the non-Federal dollars for Targeted Case Management. Eliminating this "optional" service, would require eliminating the county funded and state funded service. This would mean a dramatic cost shift to counties.

Optometrist ($1,355,496) – There are few alternative resources for eye care except for physician ophthalmologists, whose costs would be higher.

Podiatric ($588,438) – Alternative interventions would likely fall to orthopedic surgeons, which would be more costly.

Other Practitioners ($1,203,094) – Advanced Registered Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Audiologists, Rehab Agencies, Area Education Agencies, Local Education Agencies, CRNA's, clinical Social Workers, and Early Access Service Coordinators all provide medically necessary services.

Chiropractic ($1,255,763) – Alternative treatments would include more expensive treatment options such as physical therapy, osteopathic manipulative treatment, or treatment by orthopedic surgeons.

Health Maintenance Organizations (HMO) optional services ($746,241) – Ambulance, optometric, podiatry, durable medical equipment, and chiropractic services provided through contracts with HMO's.

Mental Health-Related optional services ($4,256,128) – Services, such as community mental health centers, psychologists, day treatment or partial hospitalization are designed to reduce or control a person's psychiatric or psychosocial symptoms so as to prevent relapse or hospitalization, which would be more costly.

MediPASS Patient Management ($233,044) – The coordination and consolidation of care has been instrumental in requiring that enrollees seek care from the private physician office, rather than hospital emergency rooms.

Postage ($429,050) – Postage expenses associated with mailing Medicaid identification cards to Medicaid eligible persons.

Provider Rates. On the question of rate adjustments, it is difficult to set priorities without good data and careful analysis on how Medicaid's current rates for all services compare to rates paid by other third party insurers for all similar services to a similar population in similar areas of the State. We expect to get such data beginning in SFY 2006. It is likely that such data and analysis will only begin to be useful in SFY 2007. In recognition of current state statutory and regulatory requirements, however, this offer includes funds for:

$7,048,370 Rebasing nursing home rates.
$10,425,799 Making the adjustment for practitioner rates to bring them into line with the Medicare RBRVS rates.

Hospital Disproportionate Share (DSH) program. If the State were to distribute to hospitals in SFY 2006 (under the distribution formula in effect in SFY 2005), the 16% increase over SFY 2005 DSH allotment, it would need to spend $1,975,584 in additional State dollars. This offer includes funds for that purpose.

IMPORTANT: This offer relates to: Offer H_401_07 which would provide Medicaid funding under SFY 2005 eligibility rules for all mandatory services, and the costs of program administration/management, to Offer H_401_13 relating to Part D Medicare, and to Offer C_401_34; H_401_34 which would create a universal assessment tool – a key part of our strategy to rebalance the State's long term care system away from institutional and towards home and community based care.

OFFER JUSTIFICATION

The offer is appropriate and should be accepted because it will:

- Provide low-income adults, including parents, the disabled, the elderly and pregnant women with timely access to appropriate quality medical care.
- **Medicaid is a critical part of the State's economy**. It will bring in more than $1.5 billion dollars in SFY 2006 to Iowa from the federal government. (To assess the full impact of these dollars on jobs and income and state tax revenues, one should also take into account the "multiplier" effect of these federal dollars). Also there are numerous Iowa communities where Medicaid is the largest third party payor for medical service providers who are key players in the local economy.
- Establish the administrative infrastructure necessary to support a performance based, evidence driven system of quality acute, preventive and long-term care services.
- Help shift the balance from institutional long-term care to community based long term care and from long term care generally to healthy aging by building a more informed membership.

PERFORMANCE MEASUREMENT AND TARGET

- Percentage of state long-term care resources devoted to home and community-based care. Target = 2.5% over SFY 2005.
- Percentage of Medicaid families who are aware of and know how to access preventive health care services. Target = 15% increase over SFY 2005.
- Pharmacy costs per member per month. Target = 5% increase over SFY 2005.
- Percentage of children and parents (other than those with special health care needs) with regular access to managed care (either PCCM or capitated). Target = 95%.
- Timely implementation of Iowa Medicaid Enterprise (IME). Target = Full federal system certification by March 2006.

PRICE AND REVENUE SOURCE

Total Price: $738,563,415

Expense Description	Amount of Expense	FTEs
Medical Assistance	**$738,563,415**	
Total	**$738,563,415**	

Revenue Description	Amount
State General Funds	**$168,310,944**
Federal Matching Funds	**$433,919,964**
Other Funds (Includes Drug Rebates, and County Share)	**$136,332,507**
Total	**$738,563,415**

OFFER FOR IOWANS

IDENTIFYING INFORMATION
Offer Identifier: H_588_5a

Offer Name: Building Healthy Communities in Iowa—Iowa's Unity in Health

This offer is for an: improved existing activity (new funding).

Result(s) Addressed: Improve Iowans Health

Participants in the Offer: IDPH

Additional Stakeholders: Minority health coalitions, faith based community organizations, state based organizations, national and regional government agencies, educational institutions.

Person Submitting Offer: Mary Mincer Hansen, RN, PhD

Contact Information: Iowa Department of Public Health; Phone: 515-281-8474 Fax: 515-281-4958

OFFER DESCRIPTION
The Health Buying Team is seeking offers that assure "All Iowans Have Access to Quality Care," that "Improve Preventative Strategies and Health Education," "Improve Quality of Life," and "Improve the Health Care System." The Iowa Department of Public Health, in collaboration with the partners listed above, proposes the following activities to achieve these strategies:

1) **Improved Service – Office of Multicultural Health:** IDPH proposes creating an Office of Multicultural Health to enhance public and private efforts to decrease and eliminate the health disparities experienced by minority and immigrant/refugee populations. The office will initially employ four FTE employees: an IDPH "Executive Officer" to serve as lead staff, a Minority Health Liaison, an Immigrant/Refugee Health Liaison, and an administrative assistant.

   Specifically, the office will have the staff and resources to do the following:
   - Increase financial support and technical assistance to the five Minority Health Coalitions established in 2000 (Blackhawk, Polk, Scott, Tama and Woodbury Counties). These coalitions have suffered from a lack of financial and staff support due to budget constraints. A new Office of Multicultural Health would be able to reestablish these coalitions (Polk, Blackhawk and Woodbury are still meeting, while Scott and Tama are not). All the coalitions, even those no longer functioning in a formal fashion, have expressed interest as they continue to play a part in targeted IDPH public health campaigns. Office of Multicultural Health funding would provide these existing and new coalitions with grants to cover coalition operational costs; provide assistance with approved program activities; hold regional meetings on minority/immigrant/refugee health and a state minority-health-coalition conference; and collaborate on public health assessments the coalitions are interested in conducting.
   - Collaborate with local public health agencies and health care providers to improve minority/immigrant/refugee populations' access to high quality and culturally competent health care throughout Iowa.
   - Work closely with the Iowa Departments of Human Services and Human Rights to address more effectively the health care access needs of minority/immigrant/refugee populations.

- Enhance Iowans' awareness of the health care needs of minority/immigrant/refugee populations.
- Increase Iowa minority/immigrant/refugee participation in the health care industry by increasing recruitment and retention within the Iowa health care professional and paraprofessional workforce.
- Work with the IDPH Minority Health Advisory Board, which was established in 2001, but whose development and efficacy has lagged due to limited funding.
- Advise IDPH management and staff on minority/immigrant/refugee health issues and increase IDPH awareness of minority/immigrant/refugee public health needs.
- Promote the participation of minority/immigrant/refugee group members in IDPH planning and policy-making activities.

To support and strengthen the activities above, IDPH will perform the following activities using federal funding:

1) **Refugee Health:** Assure that all newly arriving refugees receive a health assessment. Screen refugees for potential health risks and refer those with any identified health or medical problems for medical attention. Assessments are important for the refugees, the sponsoring families, and all Iowans to prevent the spread of communicable or infectious diseases that may have been undetectable before the refugee entered the United States. Consult with agencies wishing to provide culturally specific services as well as prevention education programs to refugees and their families.

OFFER JUSTIFICATION

Return on investment: When an Office of Multicultural Health is established, IDPH will be able to fully pursue this aggressive agenda in a way that our current Minority Health Liaison Title V block grant funding does not allow us to do. Without increased state support, IDPH will be unable to target the health needs of our increasingly diverse population and existing networks, resource connections, and technical assistance programs will cease to exist.

Multicultural populations are at a disparate risk for many types of diseases and health problems. For example, cardiovascular disease (CVD) is the number one cause of death in Iowa. African Americans, Hispanics, and American Indians have higher rates of CVD risk factors and mortality than whites. These same groups tend to lack access to health care and health insurance coverage. The financial costs of CVD are enormous. In 2004, these conditions will cost the nation an estimated $368.4 billion in direct and indirect costs. CVD risk-reduction programs have been shown to be cost-effective. A typical program can expect to provide $1.21 to $3.29 in benefits from reduced medical costs for every $1 in costs.[1]

Cancer is the second leading cause of death in Iowa. It accounts for about one out of every four deaths in the state. Cancer illness and deaths annually cost the nation more than $180 billion in health care spending and lost productivity. Racial minorities have some cancers more often and die from some cancers more often than do Caucasians. African American men are nearly twice as likely to be diagnosed and more than twice as likely to die from prostate cancer compared to Caucasian men. This disparity in prostate cancer survival is due in part to African American men in Iowa being 50% more likely to be diagnosed at a distant stage compared to Caucasian men, resulting in a 5-year relative survival rate of 82% compared with 94% in Caucasian men. Relative survival from prostate cancer is 100% when detected at early stages. Screening for prostate cancer is an important measure to improve survival rates. In the early 20th century, cervical cancer was the leading cancer killer of women. Following the development and subsequent use of the Pap test, deaths from cervical cancer dramatically decreased. Data from the State Health Registry from 1994-1999 reported 785 cases of cancer of the uterine cervix. During the same time, 235 Iowa women died from the disease. Rates of cervical cancer were significantly higher

in African American and other minority races. Rates in Caucasian women remained stable or increased. Regular screening with the Pap test is the best method of detecting cervical cancer at an early, treatable stage.

The total annual economic cost of diabetes in 2002 was estimated to be $132 billion, or one out of every 10 health care dollars spent in the United States. The most life-threatening consequences of diabetes are heart disease and stroke, which strike people with diabetes more than twice as often as they do others. Adults with diabetes have heart disease death rates 2 to 4 times higher than those without diabetes. African Americans are 1.6 times more likely to have diabetes than non-Hispanic whites. African Americans experience higher rates of at least four serious complications of diabetes: cardiovascular disease, blindness, amputation and end stage renal disease (kidney failure). The prevalence of type 2 diabetes is 1.5 times higher in Latinos than non-Latino whites. Mexican Americans, the largest Hispanic/Latino subgroup, are more than twice as likely to have diabetes than non-Hispanic whites of similar age.

Per capita medical expenditures totaled $13,243 for people with diabetes and $2,560 for people without diabetes. When differences in age, sex, and race/ethnicity are adjusted for, people with diabetes had medical expenditures that were 2.4 times higher than expenditures that would have been incurred by the same group if they had not had diabetes.[2]

Other programs focused on improving behaviors that reduce the risk for CVD disease, cancer, and diabetes range from $1.49 to $4.91(median of $3.14) in benefits for every dollar spent on the program.[3] These programs have been shown to improve employee health, increase productivity, and yield a significant return on investment for the employer. Through the Office of Multicultural Health, access to these programs is increased and costs related to these diseases can be reduced.

Disparate and at risk/vulnerable populations: All Iowans receive services from this offer. Vulnerable populations receiving additional focus include racial/ethnic minorities, rural, underserved, elderly, youth, health providers, agencies, and organizations and rural communities.

Impact on Iowans: Iowa experienced a 97% increase in its minority population between 1990 and 2000, ranking it eighth among states in minority population growth. Specifically, census data indicates a 47% increase in African-Americans, a 46% increase in Native-Americans, a 214% increase in Asian-Pacific Islanders and a 241% increase in the Hispanic-Latino population during that period. By 2000, 7% of Iowa's population was classified as "minority" and in rural areas of the state, the minority population increased from 32,569 in 1990 to 64,197 in 2000.

Between 1990 and 1999, approximately 2,600 legal immigrants and refugees have taken up Iowa residency each year. Currently, the state's largest refugee groups are Southeast Asians (10,000) and Bosnians (7,000). The Sudanese refugee population in Des Moines Iowa, 916 as of 2001, is the largest Sudanese population outside Africa.

Iowa's minority and immigrant/refugee populations are growing, with Iowa currently ranking eighth among the 50 states in minority population growth between 1990 and 2000. The health status of Iowa's minority and immigrant/refugee populations is believed to be lower then that of the majority population. To meet the needs of these expanding populations, IDPH must expand its capacity to address minority and immigrant/refugee health issues, and assist local public health agencies and health care providers to address health concerns of new Iowans.

The IDPH Division of Health Promotion and Chronic Disease Prevention currently incorporates the Multicultural Health Consultant and the Refugee Health Liaison within its existing staff. Since the

Division is responsible for providing support for local Iowa public health services, and is charged with working closely with Iowa's 99 local boards of health to assure the core public health functions of assessment, assurance and policy development, it is the proper place for the Office of Multicultural Health within IDPH.

PERFORMANCE MEASUREMENT AND TARGET

Percentage of Iowans rating their own health at good to excellent: Baseline 88% in 2003. Target – 88%.

Percent of IDPH programs that have increased the integration of disparate populations within their plans, goals, policies and /or products, issues, information or endeavors because of contact with the Office of Multicultural Health: Baseline to be established in FY05. Target – 85%.

Percent of community based agencies that have received technical assistance, resources, or training from the Office of Multicultural Health: Baseline to be established in FY05. Target – 50%.

PRICE AND REVENUE SOURCE

Total Price: $603,327 ($523,029 state)

Expense Description	Amount of Expense	FTEs
Status Quo Direct Costs	77,592	1.15
Status Quo Administrative Costs	2,706	0.18
Improved Service Direct Costs	500,000	4.00
Improved Service Administrative Costs	23,029	0.61
Total	**603,327**	**5.94**

Revenue Description	Amount
Improved Service General Fund	523,029
Total State Funds	**523,029**
Status Quo Federal Funds	80,298
Total Other Funds	**80,298**
Total	**603,327**

REFERENCES

[1] Centers for Disease Control and Prevention. Chronic Disease Notes & Reports. Volume 17. Number 1. Fall 2004.

[2] American Diabetes Association: Economic costs of diabetes in the U.S. in 2002. *Diabetes Care* 26(3):917-932, 2003.

[3] U.S. Department of Health and Human Services. Prevention Makes Common "Cents". Washington, D.C. September 2003.

IDENTIFYING INFORMATION

Offer Identifier: H_401_21F

Offer Name: Personal Assistance Services

This offer is for a (pick one):
_____ new activity
_____ improved existing activity (describe the improvements in your narratives below)
__x__ status quo existing activity

Result(s) Addressed:
Primary:

- All Iowans Have Access to Quality Care
  - Chronic/Long Term Care
- Improve Quality of Life
  - Community Based Services for persons with special needs and vulnerable population
  - Safe and Health Living Environment for children, persons with special needs and vulnerable population

Participants in the Offer: DHS

Person Submitting Offer: Kevin Concannon

Contact Information: Mary Nelson

Code Site: 225C.46-225C.48
Appropriations: Personal Assistance Services (SF2298, Division V, Section 133, page 127, line 25)

OFFER DESCRIPTION

Personal Assistance began as a pilot project in 1995 in 3 counties in Iowa (Scott, Clinton, and Muscatine). The purpose was to provide personal assistance services to individuals with significant disabilities to help them to continue to live in their communities.

The State of Iowa and the individuals with disabilities joined together in a good faith effort to begin a new program to help people live independently. Many of the personal assistance services are now available on waiver, and those individuals who are eligible for a waiver have moved to waiver services. The individuals who are left in the PAS program depend upon these services to help them stay in their homes.

If you ask a group of individuals with significant disabilities living independently for a definition of personal assistance services (PAS), you are likely to get many answers. People with speech or hearing barriers, it will be interpretation services, those with significant physical barriers, it will be help with activities of daily living such as preparing food, completing hygienic activities, getting dressed or even eating. Individuals with sight limitations it may be driving, and, for individuals with cognitive disabilities, it may be reading. However, most individuals who depend on PAS liken it to a bridge: A

bridge between institutionalization and independence; makeshift and unstable, at best, if you are depending on Iowa's current funding system to pay for it.

Personal Assistance Services (PAS) assist individuals with a disability do tasks that individuals without a disability typically do. These support services are intended to enable individuals with a disability to live in their own home rather than in an institutional setting. With this type of assistance, people with disabilities are empowered to live more independently within their community

A pilot project was created in three Eastern Iowa counties to determine if PAS was valuable service and to make a recommendation to the legislature. After the pilot had been operating successfully for several years, a recommendation to expand it statewide was made to the Personal Assistance and Family Support Council. Since the pilot had served its purpose the project has stopped adding new clients and is slowly shrinking as clients leave the pilot because they no longer meet the eligibility requirements, they have passed away or they are moved to a Medicaid waiver program that provides equivalent services. Financial eligibility is based on the person having a taxable income of $40,000 or less.

OFFER JUSTIFICATION

The following information is drawn from the 1999 Annual Report of the Personal Assistance and Family Support Services Council. This data reflects a satisfaction survey of program participants.

- Income
  - 54% of persons in the program had taxable income of less than $10,000
  - 25% had taxable income between $10,001 and $20,000
- Consideration of out-of-home placement
  - Prior to receiving PAS services, 54% of program participants were considering moving into a residential program such as a nursing home. After receiving PAS services, none of program participants were considering such a move.
- Quality of life – % of survey respondents indicating that PAS has a positive impact
  - Reduction in family stress – 89%
  - Ability to stay in own home – 86%
  - Improvement in person's living conditions – 75%
  - Improvement in person's health and safety – 64%
- 93% of respondents were either satisfied or very satisfied with the program.

Access to Quality Care:

PAS provides access to chronic/long term care for persons with disabilities that enables them to live in their own community.

Improve Quality of Life:

To stop this service would likely force these individuals into very expensive nursing home services. The individuals who still receive Personal Assistance Services under this program are not eligible for these services through the Medicaid waivers because of income or resources; otherwise, they would have moved to one of the waivers. Until they voluntarily leave or a statewide program is available, Iowa should continue this pilot on a phasing out basis. There are currently 21 persons participating in this program.

PERFORMANCE MEASUREMENT AND TARGET

Percent of recipients prevented from going into a congregate care facility	95%

PRICE AND REVENUE SOURCE

Expense Description	Amount of Expense	FTE's
PAS Services	$151,763	0
Total	$151,763	0

Revenue Description (State General Fund Appropriations)	Amount
PAS Pilot	$151,763
Total	$151,763

OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_401_35F

Offer Name: Non-Resident Mental Health Commitment Reimbursement

This offer is for a (pick one):
_____ new activity
_____ improved existing activity (describe the improvements in your narratives below)
__x__ status quo existing activity

Result(s) Addressed:
Improve Iowans' Health

- All Iowans Have Access to Quality Care:
  - Acute/Emergency Care
  - Behavioral/Developmental Care including substance abuse and mental health treatment

Participants in the Offer: Department of Human Services

Person Submitting Offer: Kevin Concannon

Contact Information: Sally Cunningham:
scunnin@dhs.state.ia.us, (515) 281-6360

OFFER DESCRIPTION

The Code of Iowa, in Chapters 229, 125, and 232, authorizes proceedings for voluntary and involuntary (civil commitment) admission to mental health hospitals and substance abuse programs. Costs associated with these commitment proceedings, such as court-appointed attorney, hospitalization pending hearing, transport, process notification, and appeals, are to be paid either by the State or the County, depending on the individual's legal settlement status (Chapter 230, Code of Iowa).

If the person lacks legal settlement with a county, the State has statutory responsibility (Section 230.11, Code of Iowa) for eligible costs. When an individual has legal settlement the county is to pay all of the expenses related to the process of the commitment or admission. Under the same statute Counties are then entitled to reimbursement of eligible expenses. These expenses do not include the cost of treatment at a Mental Health Institute.

This appropriation is used to reimburse Counties for the expenses submitted and is a fixed amount (Iowa Code Section 8.59) of $174,809. This is a reduction of $9,589 following the FY 2002 across the board budget cuts.

OFFER JUSTIFICATION

Iowa Code provides for commitment or admission to State Mental Health Institutes and to other mental health hospitals. The normal process for all commitments and admissions is through the County in which the person resides or is found, and therefore the County incurs and pays related expenses for persons with legal settlement and also pays on behalf of the State for all others. Statute provides for a mechanism to defray these expenses when the person does not have legal settlement or their legal settlement cannot be determined. This appropriation provides for reimbursement to Counties of the eligible expenses the county paid on behalf of the State.

PERFORMANCE MEASUREMENT AND TARGET

Reimbursements will not exceed the amount of the appropriation.

PRICE AND REVENUE SOURCE

Total Price: $174,809

Expense Description	**Amount of Expense**	**FTEs**
	$174,809	
Total	$174,809	

Revenue Description	**Amount**
Total	

OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_588_13

Offer Name: Building Healthy Communities in Iowa—Violence Free Iowa

This offer is for a: status quo existing activity and new activity.

Result(s) Addressed: Improve Iowans Health

Participants in the Offer: IDPH

Additional Stakeholders: Iowa Department of Education, mental health providers, substance abuse providers, Iowa Department of Human Rights – Division of Criminal and Juvenile Justice Planning (CJJP), Iowa Department of Human Services, American Red Cross, community-based prevention and treatment programs, Iowa citizens.

Person Submitting Offer: Mary Mincer Hansen, RN, PhD

Contact Information: Iowa Dept. of Public Health; Phone: 515-281-8474 Fax: 515-281-4958

OFFER DESCRIPTION

The Health Buying Team is seeking offers that assure "All Iowans Have Access to Quality Care," that "Improve Preventative Strategies and Health Education," and "Improve Quality of Life." The Iowa Department of Public Health, in collaboration with the partners listed above, proposes the following activities to achieve these strategies:

1) **Improved Service: Suicide/Violence Prevention:** Establish a suicide/violence prevention program. Develop a state suicide/violence-prevention plan (building on the activities of a suicide prevention steering committee that has been operating for the past year) that is targeted appropriately and addresses several age-appropriate risk and protective factors in different contexts (individual, family, school, peer group, community). Gather suicide/violence surveillance data. Increase community capacity for suicide/violence prevention including bullying through professional training and community coalition-building. Target youth suicide/violence prevention through parent awareness and education, school programming, and other community intervention strategies. Offer training and technical assistance to schools to identify, assess, intervene, and refer victims of bullying and suicide ideation to community resources.

To support and strengthen the above activities, IDPH also will perform the following activities using federal or other sources of funding:

1) **Violence Prevention:** Offer training and technical assistance to health-care providers to identify, assess, intervene, document, and refer victims of domestic violence to community resources. Conduct public awareness campaigns to increase awareness of domestic violence and resources available to health care providers and the public. Reduce the incidence of sexual violence by conducting prevention activities in Iowa communities. Conduct training for community professionals assisting victims of sexual offenses and establish and maintain a support network and information/referral resource for victims of sex offenses and their families through a contract with the Iowa Coalition Against Sexual Assault.

OFFER JUSTIFICATION

Return on investment: Effective, evidence-based prevention programs focused on youth development and violence prevention offer from $2 to $23 in benefits to taxpayers and victims for every $1 in program costs.[1] For every $1 spent on youth suicide prevention, approximately $3 is saved in direct health care expenses. Additional savings come from reductions in drug and alcohol abuse, depression, school failure, and sparing families and friends the trauma of a youth suicide. Estimates of such savings are in the billions of dollars.[2]

Disparate and at risk/vulnerable populations: All Iowans benefit from these services with specific efforts targeting Iowa youth most at risk for violence and suicide.

Impact on Iowans: Suicide is the 2nd leading cause of death for Iowans aged 15-34 and the 4th leading cause of death for Iowans aged 10-14 and 35-54. Iowa has a higher rate of suicide deaths than homicides, which is typical in rural areas of the country. In 2001, 38 teens and 301 Iowans committed suicide. In 2002, 10% of Iowa 6, 8, and 11 grade students reported planning suicide while 11% reported they had attempted suicide at least once. Despite this, Iowa does not have a state suicide-prevention plan – unlike other states in our region (KS, NE, MO, IL, MN and WI).

In 2002, 12% of Iowa students in grades 6, 8, or 11 had been in a physical fight one or more times during the 12 months preceding the survey. Overall, male students are significantly more likely than female students to have been in a physical fight. Nationwide, 6.9 percent of students carried a weapon (for example, a gun, knife, or club) on school property one or more times during the 30 days preceding a 1999 survey. In Iowa, the rate was 4% of students in 2002. Additionally, in 2002, 30% of Iowa youth had been involved in sexually related behavior that they wished would not have happened and 6% had a boyfriend or girlfriend hit, slap or physically hurt them on purpose during the 12 months preceding the survey.

PERFORMANCE MEASUREMENT AND TARGET

Percent of Iowa youth who planned or attempted suicide: Baseline 5% of 6th graders, 11% of 8th graders, 14% of 11th graders planned suicide in 1999. 6% of 6th graders, 11% of 8th graders, and 14% of 11th graders reported they had attempted suicide in 1999.

Iowa Teen and Total Suicides: Baseline 38 teens and 304 total in 2001.

PRICE AND REVENUE SOURCE

Total Price: $1,225,982 ($679,937 state)

Expense Description	Amount of Expense	FTEs
Status Quo Direct Costs	527,969	1.50
Status Quo Administrative Costs	18,076	0.23
New Service Direct Costs	650,000	2.00
New Service Administrative Costs	29,937	0.30
Total	**1,225,982**	**4.03**

Revenue Description	Amount
New Service General Fund	679,937
Total State Funds	**679,937**

Status Quo Other Funds	57,553
Status Quo Federal Funds	488,492
Total Other Funds	**546,045**
Total	**1,225,982**

REFERENCES

[1] S. Aos, R. Lieb, J. Mayfield, M. Miller, A. Pennucci. (2004) Benefits and Costs of Prevention and Early Intervention Programs for Youth. Olympia: Washington State Institute for Public Policy, available at <http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf>.

[2] LL. Eggert, EA. Thompson, BP. Randell, E. McCauley. Youth Suicide Prevention Plan for Washington State. Washington State Department of Health. January 1995.

OFFER FOR IOWANS
H_216-3
Submitted by the Iowa Insurance Division, August 13, 2004
Susan E. Voss, 1st Deputy Commissioner, susan.voss@iid.state.ia.us; 281-6386
Improve the Health of Iowans
This offer is for an improved existing activity.

The Insurance Division Consumer and Legal Affairs Bureau and the Senior Health Insurance Information Program (SHIIP) will contribute positively to the Health of Iowans by providing counseling services, consumer outreach and education and enforcing the health care insurance statutes of Iowa. While Iowa may have a low uninsured rate, nonetheless, Iowans continue to seek quality and affordability in their coverage. The Insurance Division has the knowledge, experience and personnel to provide counseling and assistance when Iowans are looking for coverage. In addition, when coverage is not appropriately provided, the Division can intervene through our enforcement efforts and protect Iowans.

Our past experience shows that we can provide these services. We assist in over 16,000 yearly consumer complaints concerning coverage. Our SHIIP program serves close to 50,000 seniors yearly and has saved them close to $.5 million each year in unnecessary health care coverage. SHIIP staff travel throughout the state meeting one-on-one with consumers. They train volunteers in all counties to answer questions about health care coverage and long term care coverage for seniors. There is a 1-800 number and specific documents for seniors to determine if their coverage is appropriate. All these services are free.

Our consumer outreach to the communities includes speeches, educational press releases, videos, and pamphlets and brochures explaining health care insurance. We serve Iowans during the State Fair our booth. Last year our Consumer and Legal Affairs Bureau recovered close to $2.5 million in unnecessary charges and payments made by consumers. We also assist Iowans by providing direction on many patient protection issues including the External Review process which provides consumers an avenue to appeal denials of care by health care plans. Our web site provides for Iowans to E-mail us with health care coverage questions. We guarantee a response in 48 hours.

This offer will ensure that Iowans have assistance in seeking affordable and cost-effective health services. Other areas of the office review the forms and overall status of health insurance carriers. But, the SHIIP and Consumer and Legal Affairs Bureau work directly with the consumers and are their eyes and ears when they do not understand the process. Savings attributable to these to areas cannot be overstated.

Our continued service in these areas will be measured by ensuring that 90% of complaints are handled appropriately in 80 days. We will increase our outreach efforts to Iowans by 5% (through an established baseline.) We will provide at least 10 educational press releases during the year on topics that include health care coverage education. We will update our website to provide more information and opportunities for Iowans to contact us. The Division will internally provide for cross training and web updates. With the addition of another staff person to provide immediate assistance to consumer questions, the Enforcement staff can review legal issues concerning health care coverage and commence legal actions if necessary.

Total Price for this Result: **$1,712,184**

Expense Description	**Amount of Expense**	**FTEs**
Operations of Consumer and Legal Affairs	$1,356,106	18
SHIIP	356,078	5

Total	**$1, 712,184**	**23**

Revenue Description	**Amount**
Appropriable receipts pursuant to 505.7 (3) and (4)	$1,356,106
Federal Grant to SHIIP	356,078
Total	**$1,712,184**

OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_588_14

Offer Name: Building Healthy Communities in Iowa—Improving Patient Safety in Iowa

This offer is for a: new activity.

Result(s) Addressed: Improve Iowans Health

Participants in the Offer: IDPH, Iowa Department of Human Services, Iowa Veterans Home, Iowa Commission of Veterans Affairs, Iowa Department of Inspections and Appeals, Iowa Department for the Blind

Person Submitting Offer: Mary Mincer Hansen, RN, PhD

Contact Information: Iowa Department of Public Health; Phone: 515-281-8474 Fax: 515-281-4958

OFFER DESCRIPTION

Medical care has the potential to cause harm and it does for hundreds of thousands of people every year nationwide. Medical errors are now the eight leading cause of death and injury among Americans with error-caused death in hospitals alone exceeding the number of deaths attributable to motor vehicle accidents, breast cancer or AIDS every year. Simply put, though the quality of healthcare is good in the United States, health care is not as safe as it should or can be.[i]

A medical error could mean a health-care provider chose an inappropriate method of care, such as giving a patient a certain asthma drug without knowing that he or she was allergic to it. Or it could mean the health provider chose the right course of care but carried it out incorrectly, such as intending to infuse a patient with diluted potassium chloride--a potassium supplement--but inadvertently giving the patient a concentrated, lethal overdose. The seemingly simple process of giving a patient medicine--the right drug, in the right dose, to the right patient, at the right time--is, in reality, teeming with opportunities for error. It is estimated that preventable medication errors result in more than 7,000 deaths each year in hospitals alone, and tens of thousands more in outpatient facilities.[ii] In the Harvard Medical Practices Study of adverse medical events (Leape, 1991), which was based on 30,195 randomly selected records from 51 hospitals in New York State, the researchers found that drug complications represented 19 percent of all adverse events. The researchers concluded that 58 percent of injuries and deaths due to drug reactions were preventable, and 27.6 percent of such complications were due to negligence. According to this study, antimicrobial drugs were the class of agents most commonly associated with adverse drug events. Misuse of antimicrobial drugs not only exposes individual patients to an increased risk of a poor treatment outcome, but also leads to the emergence and spread of drug-resistant microorganisms, which may place other patients and health care workers at risk of infection.

Fortunately, most of these errors result in what have been referred to as near misses. A near miss is defined as an act that could have harmed the patient but did not do so as a result of chance (e.g., the patient received a contraindicated drug but did not experience an adverse drug reaction), prevention (e.g., a potentially lethal overdose was prescribed, but a nurse identified the error before administering the medication), or mitigation (e.g., a lethal drug overdose was administered but discovered early and countered with an antidote). Sadly, however, a small proportion of errors do result in adverse events that

is, they cause harm to patients exacting a sizable toll in terms of injury, disability, and death.[iii] Errors in medication delivery are the largest single cause of medical errors in hospitals.[iv]

People in hospitals are just a small proportion of those at risk. Doctors' offices, clinics, and outpatient surgical centers treat thousands of patients each day; retail pharmacies fill countless prescriptions; and nursing homes and other institutional settings serve vulnerable patient populations.

The Iowa Department of Public Health and Department of Human Services propose to work together with other member agencies of the Health Enterprise Management Team (HEMT) in a unique collaborative quality initiative to improve the quality of health care and reduce injury and deaths due to medical errors in Iowa. We propose to:

1. Engage stakeholders, including state agencies, health professionals, health care institutions (hospitals and nursing facilities), payers, insurers, hospital, nursing and medical associations, business, and consumers to create awareness of the issues, costs and consequences of medical errors.
2. Research and share best practice information regarding strategies to improve safety and reduce medical errors. This initiative will lead to creating a culture supportive of errors reporting is a starting point in reducing future medical errors.
3. Facilitate discussion about and local implementation of interventions designed to enhance patient safety
4. Standardize data collection and metrics used to analyze and present performance data.
5. Explore introducing legislation to support tracking of data and creating an environment that supports learning and improving results. 21 states now have some type of mandatory reporting system for medical errors, according to a report issued by the National Academy of State Health Policy. The trend among states introducing new mandatory systems is to: a) establish them in statute, as opposed to regulation, b) offer strong comprehensive protection of reported data, and c) release data only in aggregate form. Seven of the 21 states with mandatory reporting systems release incident specific data. Fourteen states currently issue or plan to issue aggregate reports. Of these, five states have or plan to issue aggregate reports with individual facilities identified.[v],[vi]
6. Develop a consumer, professional, and policy maker education strategies, including accountability reporting of aggregate data regarding medical errors. Including the design and production of educational materials similar to those done in other states, e.g., Pennsylvania Patient Safety Collaborative's *The Elements of a Culture of Safety* and *Your Role in Safe Medication Use: A Guide for Patients and Families* by the Massachusetts Coalition for the Prevention of Medical Errors.[vii]
7. Join and participate in the Patient Safety Improvement Corps (PSIC), an Agency for Healthcare Research and Quality (AHRQ) and Veterans Administration (VA) partnership program. The Patient Safety Improvement Corps seeks to improve patient safety by providing knowledge and skills to teams of State field staff and hospital partners selected by States. Eligible field staff includes patient safety officers and those responsible for patient safety reporting and analysis as well as intervention initiatives. **The PSIC program is tuition free.** Teams selected to participate are reimbursed for air fare, lodging, per diem, and local travel costs following the completion of each one-week session and within approximately one month of submission of a completed travel voucher[viii]

OFFER JUSTIFICATION

The number of Iowans injured or who die from medical errors is currently unknown. Estimates at the national level range up to 200,000 deaths each year, making medical errors a leading cause of death or injury. Extrapolating and applying national data to Iowa shows that as many as 1,000 Iowans may have died due to medical errors in 2002.

This offer will address several issues critical to Iowans: Reducing deaths and injury due to medical errors; quantifying the number of deaths attributable to medical errors; identifying potential best-practice interventions in reducing the number of deaths; and promoting implementation of best practices based on evidenced-based research.

The goal of creating a reporting system and tracking data related to medical errors is not to count the number of reports. But rather, to properly analyze cases and develop recommendations for those who are empowered to make change happen. Experts in the field of patient safety report that understanding the "root" of the problem and the "contributing" factors are winning strategies; counting errors and comparing performance are not.

There are many aspects of a health care institution's operations that contribute to overall quality and safety of care. Implementing a range of practices would reduce the risk of harm in multiple processes, systems, or environments of care. The Federal Agency for Healthcare Research and Quality's University of California San Francisco-Stanford University Evidence-Based Practice Center has reviewed 220 patient safety practices based on scientific evidence and provides recommendations for implementing best practices. Using these and other reviews of patient safety practices will improve the quality of health care for all Iowans. Best practices do exist and are being documented everyday. The VA healthcare system is a strong example of using best practices. They undertook a major effort to reduce errors by installing a bar code system for medication distribution. The result: medication errors were reduced by 70% in 5 years.

Although quality improvement programs within health care organizations exist in Iowa and across the nation, these can be enhanced. The strategies proposed in this Offer address what are seen as the multiple major obstacles that must be overcome to reduce preventable errors and deaths. The more serious are:

1. Lack of awareness that a problem exists.
2. A traditional medical culture of individual responsibility and blame.
3. The lack of protection from legal discovery and liability, which causes errors to be concealed.
4. The primitive state of medical information systems, which hampers efficient and timely information collection and analysis.
5. Inadequate allocation of resources for quality improvement and error prevention throughout the health care system.
6. Inadequate knowledge about the frequency, cause and impact of errors, as well as about evidence of effective methods for error prevention.
7. Lack of understanding of systems-based approaches to error reduction (such as those used in aviation safety or manufacturing) and the perceived difficulty of adapting those approaches to the health care sector.

This offer relates directly to Goal #3 of the Leadership Agenda: All Iowans have access to quality health care. The Health buying team is seeking offers to assure that "All Iowans have access to quality care" and that "improve the health care system." This offer is an innovative approach that uses best practices to improve the safety and reduce health care costs for Iowans by addressing a vital issue in need of improvement.

PERFORMANCE MEASUREMENT AND TARGET

1. Percent of Iowa hospitals implementing identified best practices: Baseline established in FY06.
2. Number of medical errors reported per 100,000 patients served. Baseline established in FY06
3. Number of deaths attributable to medical errors: Baseline established in FY06.

PRICE AND REVENUE SOURCE

Total Price: $1,000,000

Expense Description	Amount of Expense	FTEs
New Service Direct Costs	957,374	4.00
New Service Administrative Costs	44,094	0.61
Total	**1,001,468**	**4.61**

Revenue Description	Amount
New Service General Fund (A portion of these funds would go to each of the HEMT member departments and DIA)	**1,001,468**
Total	**1,001,468**

REFERENCES

[i] To Err is Human: Building a Safer Health System (2000), Institute of Medicine

[ii] American Hospital Association. *Hospital Statistics*. Chicago: American Hospital Association; 1999; Bates DW, Cullen DJ, Laird N, et al. Incidence of adverse drug events and potential adverse drug events: Implications for prevention. ADE Prevention Study Group. *JAMA* 1995;274(1):29-34; Brennan TA, Leape LL, Laird NM. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. *New Engl J Med* 1991;324:370-6; Centers for Disease Control and Prevention (National Center for Health Statistics). Births and deaths: Preliminary data for 1997. *National Vital Statistics Reports* 1999;47(4):27; Leape LL. Error in medicine. *JAMA* 1994;272:1851-57; Porter J, Jick H. Drug-related deaths among medical inpatients. *JAMA* 1977;237(9):879-81.

[iii] Patient Safety: Achieving a New Standard for Care (2004), Board of Health Care Services, Institute of Medicine

[iv] To Err is Human: Building a Safer Health System (2000), Institute of Medicine

[v] National Academy for State Health Policy, Statewide Patient Safety Coalitions: A Status Report, May 2002.

[vi] To learn from errors, the aviation industry experimented with different models, but found it most useful to have a large national database of information that can be analyzed for patterns of underlying causes of mistakes. This ensures that data from events that rarely occur, but which have dire consequences, can be more readily identified. At the moment, no comprehensive system of data collection exists that will drive the Nation's efforts to learn from medical errors.

[vii] Ibid

[viii] Only States may submit applications, but the State applications may include up to two hospital partners as selected by the State (for a total of four participants, maximum per state). If the team is two members, it may be two State staff or one State staff and the State's one selected hospital partner. If the team is three members, two must be from the State and one may be the State's single selected hospital partner. If the team is four members, two must be from the State and two must be the State's selected hospital partners.

In no case shall the team consist of less State members than State-selected hospital partner members. *Preference will be given to teams of four members.*

Fifteen States complete the PSIC program in 2003-04 (Alaska, Connecticut, Maryland, Massachusetts, Minnesota, Missouri, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Virginia, Wisconsin). Notification via E-mail is requested no later than June 30, 2004 (of each year). The E-mail should be addressed to Caryl Lee (Caryl.Lee@med.va.gov), Tina Nudell (Tina.Nudell@med.va.gov), and Marge Keyes (mkeyes@ahrq.gov). http://www.nashp.org/_docdisp_page.cfm?LID=6F0BB363-FDA8-4190-90E8108E14942BAA

The primary goal of PSIC is improving patient safety by providing the knowledge and skills necessary to:

1. Conduct effective investigations of reports of medical errors (e.g. close calls, errors with and without patient injury) by identifying their root causes with an emphasis on underlying system causes.
2. Prepare meaningful reports on the findings.
3. Develop and implement sustainable system interventions based on report findings.
4. Measure and evaluate the impact of the safety intervention (i.e., that will mitigate, reduce, or eliminate the opportunity for error and patient injury).
5. Ensure the sustainability of effective safety interventions by transforming them into standard clinical practice.

OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_297_001 F

Offer Name: PACE (Program of All Inclusive Care for the Elderly) -- HEALTH

This offer is for a:

__X__ new activity
_____ improved existing activity (describe the improvements in your narratives below)
_____ status quo existing activity

Result(s) Addressed: Improve the Health of Iowans

Participants in the Offer: DEA, DHS

Person Submitting Offer: Mark Haverland, Director, Iowa Department of Elder Affairs

Contact Information: Iowa Department of Elder Affairs**,** 200 10th St, 3rd Fl., Clemens Bldg, Des Moines, Iowa 50309- 3609, Phone 515-242-3333

OFFER DESCRIPTION: In January of 2004, the Iowa Department of Elder Affairs (in collaboration with the Iowa Department of Human Services and Iowa Department of Inspections and Appeals), at the direction of the Senior Living Coordinating Unit (SLCU), was awarded a grant by the National PACE Association (NPA) and the Centers for Medicaid and Medicare (CMS), to study the feasibility of establishing PACE programs in Iowa. To that end, the counties of Linn, Johnson, Polk, Warren, Dallas and Madison were selected. In July of 2004, the feasibility studies indicated PACE programs would likely be viable in the counties studied. Currently, there are providers or partnerships of providers interested in establishing PACE program in the defined geographical regions.

PACE is a managed care product that includes both health care and long-term care. PACE is a merger of Medicare and Medicaid under a capitates managed care product, serving primarily low-income dual eligible adults over the age of 55. PACE is a currently allowed under the Iowa Department of Human Services state plan amendment and administrative rules. As recommended by the National PACE Association, locating a PACE coordinator within the State Unit on Aging (as is done in the states of Arkansas in Kansas) in consultation with DHS is a proven model within the state management of PACE programs.

PACE is of benefit to the state as it provides additional choices in long-term and health related services to seniors; assists the state in containing the cost of Medicaid programs and assists states in making Medicaid expenditures more predictable. PACE may assist the state in leveraging additional dollars via the broad scope of services available under the PACE program, its integration with Medicare and the broad base of knowledge within the PACE system related to Medicaid reimbursement.

OFFER JUSTIFICATION

Matching funds to support this new FTE must be obligated so that federal grant monies may be pursued; **approximately a 300% return on investment.** The PACE feasibility study conducted in June of 2004 indicated there is a market in Iowa for dual eligible adults over the age of 55 in Linn, Johnson, Dallas, Warren, Polk and Madison counties. This FTE will provide statewide coordination of the PACE program, which will assist the state in containing the cost of its Medicaid program and will also help make the states Medicaid expenditures more predictable, while at the same time, increasing the choices available in long-term care and health related services to frail and vulnerable adults over the age of 55.

The requested state resources of $62,500 is expected to leverage $187,500 in federal funds (a 300% return on investment) to address the implementation of a system expected to be more cost effective for the state of Iowa and be more responsive to the individuals it serves.

PERFORMANCE MEASUREMENT AND TARGET

Establishment of an upper payment limit (UPL) to assist providers in estimating their ability to provide services under a capitates rate.

Establishment of a PACE program in a defined geographical area.

PRICE AND REVENUE SOURCE

Total Price: $250,000

Expense Description	**Amount of Expense**	**FTEs**
Staff to research and implement PACE	$62,500	1.00
Research, consultants and related costs	187,500	
Total	**$250,000**	**1.00**

Revenue Description	**Amount**
General Fund	$62,500
Federal Funds	187,500
RETURN ON INVESTMENT – 300%	
Total	**$250,000**

IDENTIFYING INFORMATION

Offer Identifier: C_401_36F, H_401_36F

Offer Name: Crisis Counseling

This offer is for a (pick one):
__X__ new activity
_____ improved existing activity (describe the improvements in your narratives below)
_____ status quo existing activity

Result(s) Addressed:
Primary: Safe Communities

- Response/Recovery -- Responding to disasters and other emergencies, and assistance and restoration for victims and communities
- Preparedness – Training and adequate resources

Secondary: Improve Iowans' Health

- All Iowans Have Access to Quality Care – Acute/emergency care, and behavioral care including substance abuse and mental health treatment
- Improving the Health Care System – Ensure availability and quality providers

Participants in the Offer: DHS (note that we would work with HSLEM and DPH to implement)

Person Submitting Offer: Kevin Concannon, Director, DHS

Contact Information: Mary Nelson, 281-5521, mnelson1@dhs.state.ia.us

Code

OFFER DESCRIPTION

Crisis Counseling Services are federally funded by the Federal Emergency Management Agency (FEMA), in partnership with the Centers for Mental Health Services (CMHS). Crisis Counseling is one part of a comprehensive disaster response and is the unique program for which DHS has primary responsibility in the behavioral health area. Another major component of behavioral health response has been Critical Incident Stress Debriefing, also known as Critical Incident Stress Management (CISD/CISM). In Iowa, the Red Cross has responsibility for CISD/CISM. States may apply for funding under the Crisis Counseling Program only when a Presidential Declaration of Disaster has been made and funding for Individual Assistance is approved. If/when there is a Presidential Declaration, the state Disaster Mental Health Coordinator (DHS), has 14 days to submit a comprehensive application for an Immediate Services Program (ISP) of Crisis Counseling, which must include a detailed needs assessment involving all known damages within all counties involved, a specific plan for recruitment, training, and deployment of crisis counselors within the state, and a detailed budget outlining all aspects of funding the program. If approved, the ISP will be authorized for 60 days from the date of the original declaration. Throughout the ISP, the state is expected to gather and report detailed information about the services provided as well as detailed information regarding ongoing needs. By the 60th day, the state must apply for a Regular Services Program (RSP) of Crisis Counseling if it believes that needs will

continue to exist for up to an additional twelve months. Again, detailed justification, training strategies, and budgets must be prepared.

Historically, Iowa has experienced great difficulty mounting a successful program for several reasons. These include that in a state such as Iowa, where major disasters do not occur frequently and can be several years in between, it has been difficult to maintain a trained workforce with any capacity at the state and local level to respond to immediate needs. Also, our approach to the delivery of these services had been, until the past year or two, to try to devolve the funds to the counties where the disasters occur and ask them to develop and administer the program locally. This resulted in chaos in that there was no understanding of the requirements of the program, wide misinterpretation of the federal guidelines resulting in inconsistent service delivery and a failure to meet federal reporting and programmatic expectations, but more importantly, there was no capacity at the local level to mount a program within the initial 60 day period, resulting in inadequate readiness and inadequate services at best.

DHS applied for and obtained a grant from SAMHSA in SFY2004-SFY2005, aimed at Enhancing Iowa's Capacity to respond to Mental Health and Substance Abuse (MH/SA) Issues in Disasters. The SAMHSA funds, in the amount of $99,999 for each of two years, were partnered with $50,000 in CMHS Mental Health Block Grant funds, to provide statewide training toward development of increased understanding of MH and SA needs related to all manner of emergencies, as well as disasters, and development of a work force of trained potential crisis counselors. A new and successful strategy for the delivery of these services has emerged from our planning and training effort. The result is a centralized approach to the delivery of crisis counseling services administered by the DHS Disaster Mental Health Coordinator, involving partnership with a non-profit organization with expertise in the delivery of mental health and crisis counseling services, for coordination of the statewide effort. This new strategy resulted in a successful application for $194,534 in an ISP, followed by a successful RSP application, approved for $253,507. In total, Iowa DHS has been able to offer $448,041 in Crisis Counseling services due to severe tornado damage and flooding of 75 Counties, which began on May 19, 2004 and will potentially, run through September of 2005. The services began almost immediately, due to approval by DHS of the use of $25,000 in CMHS block grant funds to pay for assistance in development of the needs assessment for the ISP application, training of crisis counseling staff, and provision of outreach and counseling services until the ISP was approved, approximately three weeks after the initial disasters.

If this offer is approved for funding, it would 1) provide some ongoing capacity to support the one DHS staff person, probably the Disaster Mental Health Coordinator, for 10 percent time (.10FTE, $7,500) after the life of the current SAMHSA grant, which ends June 2005, participation in statewide planning and readiness efforts, including participation in the Iowa Disaster Human Resource Council 2) support funding of an emergency sole source contract when disasters occur for the purchase of capacity to develop the initial application ($7,500), 3) support payment of crisis counselors training and service delivery between the time that a disaster strikes and the services are requested and the time the ISP can/will actually be approved. ($10,000) This period of time is generally 3-4 weeks, and 4) the funding would support the provision of training on at least a semi-annual basis which would help Iowa maintain capacity to respond with a trained work force and continue making all manner of professionals, para-professionals, first responders, voluntary organizations active in disasters, and the general public, aware of some of the mental health and substance abuse issues relative to disasters and emergencies. ($25,000)

OFFER JUSTIFICATION

Safe Communities

This offer would enable DHS to maintain a pool of trained para-professionals who are prepared and ready to respond immediately to the declaration of a disaster, such as a tornado or flooding. As a result, DHS would be positioned to activate the network and respond immediately to requests for crisis counseling related to mental health and substance abuse after a disaster. Without funding to maintain crisis-counseling capacity, critical time is lost initially after the disaster, because we have to recruit and train the crisis counselors as well as wait for the funding stream to be approved to fund them before we can deploy them to begin responding to disaster site. Research indicates that most individuals impacted by disasters can and will begin to experience the full impact of the disaster on their emotional well being after the initial clean up and recovery efforts of responding to the physical and property damage and loss of life, home, income, property, pets, crops, animals, etc. Research also indicates that if crisis-counseling services are made available to such individuals, they are significantly less likely to require entry into the formal treatment arenas for mental health and substance abuse services. FEMA and CMHS have found, over many years of outcomes related to these services that crisis counseling is not only proactive and the "right thing to do," but can actually result in fewer mental health and substance abuse needs over the long run.

This offer would also position Iowa to be in a better position to secure federal grant funding to support crisis counseling in response to a disaster. Completing the application is a very time-consuming and rigorous task that must be done within the fourteen-day time frame. A thorough and compelling grant application is critical to receiving federal funding.

Finally, this offer would enable DHS to reimburse crisis counselors even before we receive federal grant funding. Without this capacity, it's likely we would not be able to deploy crisis counselors to the impacted communities in the days between the disaster and the notice that we had approval of our federal application.

Improve Iowan's Health

As noted above, this offer would enable Iowans who experience a disaster, such as a tornado or flooding to have access to crisis counseling by trained crisis counselors. As stated above, from the federal level, a considerable body of evidence exists to show that communities recover faster with less overall long-term mental health and substance use/abuse impact if these services are made available in the weeks and months immediately following disasters.

PERFORMANCE MEASUREMENT AND TARGET

Performance Measurement	Target
Number of potential crisis counselors trained statewide and available to DHS for possible deployment as needed	Minimum of 20 per year
Time between area being declared a disaster by the Governor and deployment of crisis counselors IF requested by the Governor and IF there will be an application for ISP	5 days from Gubernatorial Declaration
Time between area being declared a disaster by the President and the initial deployment of crisis counselors	1-2 days maximum from Presidential Declaration

PRICE AND REVENUE SOURCE

Expense Description	Amount of Expense	FTE's
Contract for annual training	$25,000	0
Contract for assistance in development of needs assessment and ISP application	$7,500	0
Reimbursement for crisis counseling until federal grant approved	$10,000	0
Support of DHS Capacity to implement training and participate in state level planning, readiness, and implementation activities (additional capacity can be added if/when ISP and RSP applications are approved)	$7500	.10
Total	$50,000	0

Revenue Description (State General Fund Appropriations)	Amount
New appropriation to DHS	$50,000
Total	$50,000

OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_297_009 F
(Duplicate Scalability Offer Extended to Safe Communities & Health Buying Teams)

Offer Name: Substitute Decision Makers Act

This offer is for a:
__X__ new activity
_____ improved existing activity (describe the improvements in your narratives below)
_____ status quo existing activity

Result(s) Addressed: Improve the health of Iowans and improve community safety to vulnerable Iowans.

Participants in the Offer: Department of Elder Affairs, Developmental Disabilities Council, Department of Public Health, Department of Human Services, Attorney General's Office, Secretary of State, local county governments and substitute decision makers task force members.

Person Submitting Offer: Mark Haverland, Director, Iowa Department of Elder Affairs

Contact Information: Iowa Department of Elder Affairs**,** 200 10th St, 3rd Fl., Clemens Bldg, Des Moines, Iowa 50309- 3609, Phone 515-242-3333.

OFFER DESCRIPTION. Create a formal system of substitute decision making, through legislation, to keep vulnerable Iowans safe from exploitation, abuse, and neglect as well as protecting individuals' mental and physical health needs through the least restrictive option. This legislative proposal, entitled the Iowa Substitute Decision Maker Act, creates a system to allow a vulnerable adult to obtain assistance in meeting their personal care and financial management needs when no family or friends or other program is available. This system of substitute decision-making is intended as a system of last resort to be turned to only when there are not appropriate or available family members, friends or other programs available to meet the need. Iowa is 1 of 6 states that does not have a formal statewide system to ensure that persons in need of a guardian, conservator, and agent under a power of attorney or other decision maker receive assistance in making or implementing medical or financial decisions. The development of the Iowa Substitute Decision Makers System proposal occurred only after reviewing the 44 other states laws. In this way, the best parts of the laws and systems from those 44 states were blended into the Iowa proposal. This proposal, being modeled after other states programs that have worked for some 25 years, will assist a tremendous number of Iowa citizens with health care decisions, thereby keeping them safe within their communities. A statewide needs assessment conducted in Iowa determined that 3,586 individuals had physical and mental incapacities, which resulted in the need of a substitute decision-maker but there was limited or no family members available to meet this need.

OFFER JUSTIFICATION. The services to be provided through the Substitute Decision Makers Act would improve the quality of life and safety of vulnerable and dependent adults through a system that has worked in 44 other states. The act would create state and local community substitute decision-making offices to serve as a decision maker for vulnerable, at-risk or incapacitated adults who have no appropriate family or friends available to assist with needed medical or financial decision-making. Persons with capacity issues are more often victims of exploitation, abuse and neglect and often receive insufficient health care or services. The proposed system would prevent a medical crisis by allowing a decision maker to consent to medical care, obtain preventative care and treatment as well as consent to the provision of in-home care services. The proposed decision making system would also prevent a financial crisis

by ensuring income is expended to meet the basic needs of the ward/principal, thereby protecting the vulnerable adult from exploitation or scams. In addition, the state substitute decision-making office would provide training to local offices to ensure that quality care and quality decision-making is provided to the vulnerable adult. A system of substituted decision making would: prevent abuse, exploitation and scams; prevent loss of home or savings; provide an appropriate level of care for the individual in need; provide an advocate to protect and ensure safety; provide access to needed services to those who cannot consent; provide alternatives to inappropriate or poor decision makers and provide individuals with the ability to plan for incapacity. Without a system for appointment of a decision-maker, the state bears of the costs of care through increased Medicaid costs due to inappropriate placements in nursing facilities rather than utilizing community based services and through extended hospital stays for Medicaid patients.

PERFORMANCE MEASUREMENT AND TARGET

- Collecting baseline data.
- Monitoring of the programs would occur to ensure the provision of quality decision-making decisions.
- Track the number of individuals receiving home and community based services as a result of the involvement of the substitute decision makers office

PRICE AND REVENUE SOURCE

Total Price: $689,600

Expense Description	Amount of Expense	FTEs
Establishment of state program	$210,000	3.00
Establishment of two local community demonstration programs	479,600	
Total	**$689,600**	**3.00**

Revenue Description	Amount
Senior Living Trust	$689,600
Total	**$689,600**

BUDGET - IOWA SUBSTITUTE DECISION MAKER ACT

State program

Wages, office space, operating costs (3 staff)	$179,800	
Travel-monitoring and trainings	$ 10,200	
Educational materials (brochures, website, training materials)	$ 19,500	
Other expenses (professional publications, fees)	$ 500	
Total cost for state office		**$210,000**

Local programs

Wages, operating costs, office space	$164,800	
Legal fees (professional fees for legal work)	$ 60,000	
Services to buy case management for clients	$ 15,000	
Total for one local program		**$239,800**
Second local program		**$239,800**
Total cost for state program with 2 demonstration programs		**$689,600**

OFFER FOR IOWANS

IDENTIFYING INFORMATION

Offer Identifier: H_671_12

Offer Name:
Assisting Veterans in the application process for federal benefits.
This offer is for a (pick one):
_____ new activity
_____ improved existing activity (describe the improvements in your narratives below)
__X__ status quo existing activity

Result(s) Addressed:
Improve Iowans' Health: Increase efficiencies of health care/service delivery including the removal of barriers.
Participants in the Offer:
Iowa Commission of Veterans Affairs
Iowa Department of Elder Affairs
RSVP
Person Submitting Offer:
Patrick Palmersheim, Executive Director, Iowa Commission of Veterans Affairs
Contact Information:
Patrick Palmersheim, Executive Director (515-242-5331) or Diana Steiner, Budget Analyst (641-753-4324)

OFFER DESCRIPTION

The Iowa Commission of Veterans Affairs (hereinafter referred to as ICVA) located at Camp Dodge is the main state agency that provides information to veterans and their dependents regarding (1) medical resources and referrals and (2) other entitlement benefits, such as Department of Veterans Affairs (DVA) compensation and pension. ICVA is requesting funding for an agreement with RSVP, via the Department of Elder Affairs, in order to assist the veterans and/or their spouses/widows/dependents in nursing homes with the application to apply for federal V.A. benefits. ICVA will provide RSVP with the veterans' names and nursing home locations and then RSVP will return the applications to the ICVA office. ICVA will review the application and then send it to the Department of Veterans Affairs office. RSVP will provide this service in counties where there is not a County Commission of Veterans Affairs office (approximately 8 counties). In counties where there is a County Director of Veterans Affairs, ICVA will contact them and the County Director will fill out the application.

OFFER JUSTIFICATION

The effort is already being made in fiscal year 2005 to have RSVP assist in signing up as many veterans and/or their spouses/widows/dependents that are residing in nursing homes for federal benefits. The funding requested in fiscal year 2006 is to complete the sign-up program that may not be able to be completed in FY2005. It is not expected to be an on-going cost after FY2006. In future years, ICVA will work with the County Commission of Veterans Affairs offices to ensure that new veterans entering nursing homes have applied for benefits.

PERFORMANCE MEASUREMENT AND TARGET

Percent of veterans and/or their spouses/widows in nursing homes that have applied for VA benefits: 80%.

PRICE AND REVENUE SOURCE

Total Price: $100,000

Expense Description	Amount of Expense	FTEs
Personnel		
Other-Contract with RSVP	100,000	
Total	100,000	

Revenue Description	Amount
General Fund appropriation	100,000
Total	100,000